

Federally Qualified Health Center Payment Process Quick Reference Guide

Wrap Payment Process and Methodology

Superior HealthPlan will initiate claims system changes for Federally Qualified Health Center (FQHC) claims with dates of service of September 1, 2017 and later. The changes will align with the Texas Health and Human Services (HHS) contract amendment and direction related to FQHC payments, which include required claims elements for reimbursement of FQHC claims at Fee-For-Service + Wrap Service = Prospective Payment System (PPS) Encounter Rate, and encounter submission to HHS for Superior reimbursement of wrap service payment amounts.

To maintain consistent claims processes for FQHCs, Superior will require both Medicaid and CHIP claims to be billed using the requirements listed below.

General Claims Requirements

Provider must bill claims:

- On a CMS1500 claim form.
- With the rendering/servicing provider NPI/taxonomy in box 24 I/J, if required.
- With the billing provider's NPI in box 33a and billing provider's taxonomy in box 33b.
- With the location where services were provided in box 32.
 - With the NPI of the facility where the services were provided in box 32a.
 - With the taxonomy of the facility where the services were provided in box 32b (Please note: boxes 32a and 32b can differ from NPI and taxonomy in 33a and 33b).
- With the appropriate location code where the services were provided, for services provided outside the FQHC site (i.e. location 21 for inpatient hospital). *Please note: Services performed outside FQHC will be paid at the Medicaid Fee-For-Service reimbursement rate.*

Claims Requirements to Trigger PPS Rate (Medicaid Fee-For-Service + Wrap Service)

Provider must bill claims:

- On a CMS1500 claim form.
- Using **Location Code 50**.
- With the billing provider's NPI in box 33a and billing provider's **taxonomy (261QF0400X)** in box 33b.
 - 33b must be a FQHC taxonomy code to trigger PPS encounter rate payment and for Superior encounter submission.
- With a procedure code **T1015** and all applicable modifiers (AH, AJ, AM, SA, TD, TE, or U7) in order to receive an encounter payment, and a PPS rate on first service line of the claim form, in addition to appropriate procedure codes for services provided (including all applicable modifiers and the provider's usual customary charge). *Please note: Providers will not be reimbursed an encounter rate without a face-to-face encounter procedure code billed in addition to the T1015 procedure code.*
- With a modifier TH for antepartum or postpartum care.
- With the appropriate family planning diagnosis code for family planning services.
- Rendering Provider NPI/taxonomy required for THSteps and Family Planning visits.
- For each face-to-face encounter, along with the procedure code for services provided on a separate claim (example: THStep visit, BH visit and General Medical visit would be billed on separate claims).

Claims Payment

- Superior will adjudicate procedure codes submitted at Medicaid Fee-For-Service. Simultaneous wrap service (up to PPS encounter rate) will be calculated and paid for the T1015 procedure code and include reimbursement at the full FQHC PPS encounter rate.
- The total claim payment will not exceed the provider's PPS encounter rate, unless codes for after-hours services or Long-Acting Reversible Contraception (LARC) procedure codes (J7297, J7298, J7300, J7301, and J7307) are billed. *Please note: After-hours care and LARC services will be paid in addition to the provider's PPS encounters rate.*
- FQHCs with questions about denied claims or concerns about payment accuracy should call Superior's Provider Services department at 1-877-391-5921. Provider Services will be able to explain the reason for the claim denial or payment amount and determine appropriate next steps.



Superior-Family Planning
(T1015 with F2F)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>									
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/>										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>									
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>									
CITY					STATE					7. INSURED'S ADDRESS (No., Street)					7. INSURED'S ADDRESS (No., Street)				
ZIP CODE					TELEPHONE (Include Area Code) ()					CITY					STATE				
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER					11. INSURED'S POLICY GROUP OR FECA NUMBER				
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>				
b. RESERVED FOR NUCC USE					b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____					b. OTHER CLAIM ID (Designated by NUCC)					b. OTHER CLAIM ID (Designated by NUCC)				
c. RESERVED FOR NUCC USE					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO				
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>				
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.									
SIGNED _____ DATE _____										SIGNED _____ DATE _____									
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL: _____										15. OTHER DATE MM DD YY QUAL: _____									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. <u>Z3009</u> B. <u>Z01419</u> C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCP/CS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #										23. PRIOR AUTHORIZATION NUMBER _____									
1 02 08 2018 02 08 2018 50 T1015 FP AM AB 151 03 1 NPI										23. PRIOR AUTHORIZATION NUMBER _____									
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3 _____ NPI										23. PRIOR AUTHORIZATION NUMBER _____									
4 _____ NPI										23. PRIOR AUTHORIZATION NUMBER _____									
5 _____ NPI										23. PRIOR AUTHORIZATION NUMBER _____									
6 _____ NPI										23. PRIOR AUTHORIZATION NUMBER _____									
25. FEDERAL TAX I.D. NUMBER 123456789 SSN EIN <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO. _____									
27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO										28. TOTAL CHARGE \$ 351 03									
29. AMOUNT PAID \$ _____										30. Rsvd for NUCC Use _____									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION Random TX Health Center 100 Main St. Random, TX. 77777									
33. BILLING PROVIDER INFO & PH # ()										33. BILLING PROVIDER INFO & PH # ()									
SIGNED _____ DATE _____										a. 1111111111 b. 261QF0400X									
SIGNED _____ DATE _____										a. 1111111111 b. 261QF0400X									

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Superior-LARC+ WRAP with modifier U8 (340B Program)
(T1015 w/ F2F, LARC)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Form containing fields for patient information (name, address, birth date), insurance details (policy number, group number), provider information (name, NPI, address), and service details (dates, charges, diagnosis codes). Includes a table for service lines with columns for dates, charges, and diagnosis codes.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION



Superior- Sick Visit (T1015 with F2F)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																																																	
1. MEDICARE <input type="checkbox"/> (Medicare#) MEDICAID <input type="checkbox"/> (Medicaid#) TRICARE <input type="checkbox"/> (ID#/DoD#) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA BLK LUNG <input type="checkbox"/> (ID#) OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 123456789																																																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY					SEX M <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																							
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>										7. INSURED'S ADDRESS (No., Street)																																							
CITY					STATE					8. RESERVED FOR NUCC USE										CITY					STATE																																		
ZIP CODE					TELEPHONE (Include Area Code) ()					9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER																																		
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY					SEX M <input type="checkbox"/> F <input type="checkbox"/>																																		
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										b. OTHER CLAIM ID (Designated by NUCC)					c. INSURANCE PLAN NAME OR PROGRAM NAME																																		
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>																																		
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17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. _____					17b. NPI _____					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																							
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES _____										22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																																							
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. R197 B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										ICD Ind. _____										23. PRIOR AUTHORIZATION NUMBER _____																																							
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										B. PLACE OF SERVICE					C. EMG					D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCP/CS MODIFIER										E. DIAGNOSIS POINTER					F. \$ CHARGES					G. DAYS OR UNITS					H. EPSDT Family Plan					I. ID. QUAL.					J. RENDERING PROVIDER ID. #				
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CARRIER
PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION



Superior- THSTEPS with vaccines
(T1015 with F2F, immunization, and admin)

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA <input type="checkbox"/>										PICA <input type="checkbox"/>																													
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CITY					STATE					8. RESERVED FOR NUCC USE										CITY					STATE														
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a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO										a. INSURED'S DATE OF BIRTH MM DD YY					SEX M <input type="checkbox"/> F <input type="checkbox"/>														
b. RESERVED FOR NUCC USE										b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										b. OTHER CLAIM ID (Designated by NUCC)					c. INSURANCE PLAN NAME OR PROGRAM NAME														
c. RESERVED FOR NUCC USE										c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO										c. INSURANCE PLAN NAME OR PROGRAM NAME					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>														
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17b. NPI _____										20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO										\$ CHARGES _____																			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																				22. RESUBMISSION CODE _____ ORIGINAL REF. NO. _____																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. Z30014 B. Z23 C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____																				23. PRIOR AUTHORIZATION NUMBER _____																			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCP/CS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #																																							
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2 09 28 2017 09 28 2017 50 N 99391 SA EP 25 BA 100 00 1 NPI																																							
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5 _____ NPI																																							
6 _____ NPI																																							
25. FEDERAL TAX I.D. NUMBER 123456789 SSN EIN <input type="checkbox"/>										26. PATIENT'S ACCOUNT NO. _____					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$ 367 07					29. AMOUNT PAID \$ _____					30. Rsvd for NUCC Use _____									
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION Random TX Health Center 100 Main St. Random, TX. 77777										33. BILLING PROVIDER INFO & PH # () Random TX Health Center 100 Main St. Random, TX. 77777																			
SIGNED _____										DATE _____										a. 1111111111					b. 261QF0400X					a. 1111111111					b. 261QF0400X				

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